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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AHC NORTHBROOKE	**121 PHYSICIANS DR JACKSON, TN 38305**

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F 000	INITIAL COMMENTS	F 000		

An investigation of complaint TN00056230 and a Focused Infection Control Survey were conducted on 1/13/2022 through 1/15/2022 at AHC Northbrooke Health Care and Rehabilitation Center. Health deficiencies were cited as past noncompliance in relation to complaint TN00056230 under 42 CFR Part 483, Requirements for Long Term Care Facilities. There were no deficiencies cited related to the Focused Infection Control Survey.

A partial-extended survey was completed on 1/15/2022.

Immediate Jeopardy (a situation in which a provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) was identified related to the facility's failure to ensure residents were free from accident hazards when a wandering resident eloped from the facility without staff supervision. Resident #1 was found approximately 78 feet from the front entrance of the facility sitting in a vehicle in the facility parking lot.

The Director of Nursing, Regional Nurse Consultant and Regional Administrator were notified of the Immediate Jeopardy (IJ) for F-689 on 1/15/2022 at 2:59 PM, in the Conference Room.

The facility was cited Immediate Jeopardy at F-689.

The facility was cited F-689 at a scope and severity of "J," which is Substandard Quality of

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 000	Continued From page 1 Care (SQC). The Immediate Jeopardy existed from 1/7/2022 through 1/11/2022. The IJ was removed onsite when the facility implemented a corrective action plan. Corrective actions were validated by the surveyors on 1/13/2022 through 1/15/2022. The facility was cited for past noncompliance and is not required to submit a Plan of Correction.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on policy review, video camera footage review, weather website review, medical record review, observation, and interview, the facility failed to provide a safe, secure environment, and adequate supervision for a vulnerable confused resident with exit seeking behaviors for 1 of 3 sampled residents (Resident #1) reviewed for elopement/wandering and exit seeking behaviors. The facility's failure to provide adequate supervision resulted in Immediate Jeopardy when Resident #1, a vulnerable confused resident wandered out of the COVID Unit, wandered throughout the facility, pulled the fire alarm, and exited the facility unsupervised. Resident #1 was found by staff in an unlocked staff member's car.	F 689		

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The vehicle where Resident #1 was located was parked approximately 78 feet from the front entrance of the facility.

Immediate Jeopardy (IJ) is a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm and impairment or death to a resident.

The Director of Nursing (DON), Regional Nurse Consultant, and Regional Director of Operations (RDO) were notified of the Immediate Jeopardy for F-689 on 1/15/2022 at 2:59 PM, in the Conference room.

The facility was cited Immediate Jeopardy at F-689.

The facility was cited F-689 at a scope and severity of "J," which is Substandard Quality of Care (SQC).

The Immediate Jeopardy existed from 1/7/2022 through 1/11/2022. The facility's corrective action plan, which removed the immediacy of the jeopardy, was received and corrective actions were validated onsite by the surveyors on 1/13/2022 through 1/15/2022.

The IJ was cited as past noncompliance and the facility is not required to submit a Plan of Correction.

The findings included:

Review of the facility's policy titled, "Elopements and Wandering Patients," revised 6/21/2021, revealed "...Purpose: This facility ensures that

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residents who exhibit wandering behavior..receive adequate supervision...Wandering is a random or repetitive locomotion that may be goal directed... (e.g. the person appears to be searching for something such as an exit) or non-goal or aimless...Elopement occurs when a resident leaves the premise or a safe area without authorization...and/or necessary supervision to do so..."

Review of the medical record, revealed Resident #1 was admitted to the facility on 1/7/2022 with diagnoses of COVID 19, Vascular Dementia with Behaviors, Acute Renal Failure, Alcoholic Cirrhosis, Fatty Liver, Benign Prostatic Hyperplasia, Insomnia, Cataracts, Edema, and a history of Nicotine Dependence.

Review of the Nurses' Notes and progress notes revealed Resident #1 was admitted to the COVID unit at 8:00 PM on 1/7/2022. Resident #1 exited the COVID unit and wandered unaccompanied throughout the building. At approximately 11:15 PM, Resident #1 pulled fire alarm, and exited the building unsupervised. Upon return to the building, Resident #1 exhibited increased exit seeking behaviors, and became combative and aggressive with staff. Resident #1 was transferred back to an inpatient Behavioral Hospital.

The video camera footage submitted by the facility to the State Agency was a recording of the camera footage. The footage submitted did not have a date or time that would verify the date and time of the incident. The length of the video footage was 3 minutes and 49 seconds.

Review of the video footage revealed the

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following:

Resident #1 entered the lobby unsupervised, pushed on the door, pulled the fire alarm, and exited the facility. Approximately 57 seconds later, a staff member walked to the lobby, opened the door and looked outside. The staff member closed the door, turned around, and started walking down the hall and out view of the camrea. Her back was facing the door to the outside. Approximately 34 seconds later, the same staff member walked back to the door, did not open the door, looked outside, and then turned around and started walking down the hall again with her back to the door. Then four additional staff members came to the lobby, opened the door, and walked outside the facility. The staff members brought Resident #1 back inside the facility. The resident was wearing a t-shirt, a pair of pants, and slip on house slippers.

Review of the Nurse Event Note dated 1/8/2022, revealed "...DETAILED DESCRIPTION OF OCCURRENCE: Admission to COVID unit, pulled fire alarm then exited front door..."

According to the Local Weather.com, the temperature on 1/7/2022 at 11:15 PM was 25 degrees Fahrenheit.

Review of a witness statement dated 1/7/2022 at 1:52 AM, written by Certified Nursing Assistant (CNA) #3, revealed "...we [staff] were standing at the nursing station trying to figure out where he [Resident #1] belonged when he started to walk off...I stayed at the nurses station thinking he would go back to his room when I saw he was at the front door...I walked to the double doors and I saw him pulling and pushing on door and

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messing with fire alarm so I walked back to the nursing station. But before I got there he had pulled the alarm...me and other CNA's headed to the front door we couldn't find him and had reason [to believe] he went outside...the other CNA found him at a car in the parking lot..."

During an interview on 1/14/2022 at 12:52 PM, Licensed Practical Nurse (LPN) #1 stated, "...noticed there was a man on the hall that I did not know...he was walking around...the fire alarm went off and they told me they found him rummaging in my car...I did not lock my car that night..."

During a telephone interview on 1/14/2022 at 2:04 PM, CNA #1 stated, "...a man was on the hall that I did not recognize...trying to find out who he was I walked him over to short stay hall...a few minutes later staff brought him back saying they didn't know who he was...I went to the COVID Unit to ask nurse if a patient was missing...he did not know...the fire alarm started alarming I noticed the man was gone...I went to the front lobby and then went outside, and I did not see him then I saw him...inside a car I saw his head bobbing up and down...he was rummaging through a parked car in the parking lot...he was physically inside the car...I coached him out of the car and back inside the building, he said 'the police are after me'..."

During a telephone interview on 1/14/2022 at 2:39 PM, LPN #3 stated, "...[Named CNA #2] asked me to keep eye on him...he was saying 'it is time to go'...I left him on the short stay hall and headed toward LTC [Long Term Care] hall and the fire alarm went off..."

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During an interview on 1/15/2022 at 7:45 AM, LPN #3 stated, "... I was working the COVID Unit and admitted a resident [Resident #1] about 8:00 PM...a CNA asked me if I had a patient missing before I could answer, the fire alarm started sounding and I noticed the admitted resident was not in his room...the COVID Unit doors alarm had been turned off and did not sound when the door opened...I did not know that he had left the unit..." LPN #3 confirmed the COVID door alarms were turned off when Resident #1 left the COVID Unit and were not turned back on until the resident returned to the COVID Unit.

During an interview on 1/15/2022 at 11:00 AM, the Regional Director of Operations (RDO) was asked why they did not consider the incident an elopement event. The RDO stated, "...because of how the staff responded to the alarm...he was only gone a couple of minutes when staff brought him back in...it was less than 2 minutes...We [facility administration] have re-educated staff on exit seeking behaviors and elopement and what staff should do..."

During an interview on 1/15/2022 at 11:05 AM, the Director of Nursing (DON) stated "...after the elopement the staff was [were] in-serviced about exit seeking behaviors and educated to stay with residents if they exhibited exit seeking behaviors..." The DON confirmed staff should have stayed with the resident when the resident was wandering the halls and when the resident was observed pulling and pushing on the front entrance door.

Observation of the parking lot on 1/15/2022 at 11:15 AM, revealed the Maintenence Assistant used a meausiring device to measure the

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distance from the front door to the location that Resident #1 was found. The distance was 78 feet.

During a telephone interview on 1/15/2022 at 1:18 PM, CNA #2 stated, "... I was trying to find out who that man was walking around the halls...a CNA said, 'he is gone', the fire alarm went off...I turned for a split second he was gone...the man was headed toward the front door..."

The facility's corrective action plan included the following:

On 1/7/2022-1/11/2022, the facility implemented the following:

1. A 100 percent (%) Elopement risk Assessment Audit was initiated by nurse managers on 1/7/2022 and was completed on 1/8/2022. The surveyors reviewed the elopement assessments, audits, and interviewed staff on all shifts.

2. A 100% medical record review was initiated on 1/7/2022 and was completed on 1/8/2022 by nurse managers, observing for confused patients with any exit seeking behaviors. The surveyors reviewed medical records and observed residents on all shifts.

3. Staff education on elopement and wandering/exit seeking behaviors was initiated on 1/7/2022 and is ongoing. No staff will be allowed to work until the education is completed. The surveyors reviewed in-service logs and interviewed staff on all shifts.

4. A fire alarm pull station cover was ordered to reduce the risk of confused patients pulling the

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fire alarm. The fire alarm covers were ordered on 1/8/2022 with completion of installation and staff in-service on 1/11/2022. The surveyors checked the fire alarm covers, reviewed the in-service logs, and interviewed staff on all shifts.

5. On 1/8/2022, an Ad Hoc (as needed) Quality Assurance Performance Improvement (QAPI) Meeting was conducted to discuss the incident with the Administrator, Regional Nurse Consultant, RDO, DON, and Assistant Director of Nursing attending. The QAPI Action Plan consisted of the following: A Confused Patient with Behaviors pulled the fire alarm. A Root Cause Analysis Template was completed. Covers were placed on the fire alarms so that if the cover was pulled, an alarm is activated. The Medical Director and Responsible Party were notified of the incident. The surveyors reviewed the facility's action plan and interviewed administration.

6. On 1/8/2022, 100% of wander guard (a mechanical bracelet device that will cause the door to alarm when the resident gets close to the door) audits were completed. The surveyors reviewed the audits, reviewed the medical records, and interviewed staff on all shifts.

7. The alarms to the doors of the COVID Unit will be checked by staff at the beginning of each shift and the end of each shift. The surveyors interviewed staff on all shifts.

8. A form was developed and when a new admission is to be admitted to the facility, the resident's name and room number will be placed on the form and the form will be placed at all Nurses' Stations. The surveyors interviewed the Regional Nurse Consultant and staff on all shifts.

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